| t., Baltimore 159                          | 0.1000   |
|--|--|
| OF DEATH                                   | Reg. Dist. No. 28/10   |
| . USUAL RESIDENCE (HOME                    | ce of mother)  |
| ity or town                                | County   |
| treet No. (1f rural,                       | give LOCATION)   |
| .(α) If veteran, name war                  |  |
| Lan  | 3. (b) Social Security Number  |
|  | CERTIFICATION  5 19.47 21 8 A  |
| 1. I CERTIFY that death occurred on the da | te above etated; that I attended deceased from  19.7.7. to 7.0.5.19.4.7.  Factor 5.19.4.7. |
| mmediate cause of death                    | DURATION   |
| Primature                                  | birth 75mm   |
|  |  |

FEE 10 1947
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## (N)

correct age

#### CERTIFICATE OF DEATH

Reg. Diat. No. ....

| Y  |   |
|--|---|
| 1. PLACE OF DEATH: St. Mary's  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (For newborn infants give residence of mother)  State         |
| City or town   | Sk. I   |
| How long in above place of death?  | (if outside city or town limits, write RURAL and give nearest town)                                   |
| Hospital, Institution, or street address where death occurred:                               | Streel No.  |
| h. 4 - 1-4   | (If rursl, give LOCATION)  2.(a) If veleran, name war   |
| How long in hospital or institution?   |   |
| 3. (a) FULL NAME Wally Canter  | 3. (b) Social Security Number   |
| 4. Sex 5. Color or race (a) Single, married, widowed, or divorced                            | MEDICAL CERTIFICATION   |
| female Coloned widowed   | 20. DATE OF DEATH. February 9 19 47 21 4:30 A M   |
| 6.(b) Name of husband or wife  | 21. I CERTIFY that death occurred on the date above stated; that I allended deceased from             |
| e (a) Mallus plus and  | February 1 19 47 10 Feb. 9 19 47  |
| 7. Birth date of 7 / 7 - 2   | and that I last saw h 2 alive on F-6. 5   |
| deceased (mo., day, yr.)  8. AGE: Years   Months   Days   if less than one day               | Immediais cause of death  |
| 947hrsmin.   | Coron monors 2 hours  |
| 9. Birthplace  | Due to Henralege d'articoloris  |
| 10. Usual occupation 10016   | James Degenvalon.   |
| 11. Industry or business   | DUC (U  |
| 12. Name Juknoum  13. Birthplace   | Other conditions  |
|  | (Include pregnancy within 3 months of death)  |
| 14. Maiden name. Lf. suksnown  15. Birthplace  |   |
| W 15 Rightniage  | Major findings of operations.   |
| M. 'Lu canda's   | Date of op.   |
| 16. Informant Address  | Antopsy results PHYSICIAN: Please underliee the cause to which death should be charged statistically. |
| b · 1  | 22. VIOLENCE: If death was due to external causes, fill in the following;                             |
| Burial, cremation, or removal, Which?)  Date thereof (Aurial, Cremation, or removal, Which?) | Accident, suicide, or homicide  |
| Cemetery or crematory Mt. Sion   | Where did Injury occur?   |
| Location St. Jusqu'es Mess   | Injured at home, farm, industry, public place (where?)  |
| 18. Fugeral director exest. L. Gahinson  | Means of Injury tnjured at work?  |
| Address Dumenon, ma.   | 23. SIGNATURE. The Harrot m)  |
| 19   | Address Lewington Park Ind Date signed Feb. 10, 199   |

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The is especially important. Physicians: please write the causes of death clearly and legible

9-45-15M

VS A15

PLEASE



PLEASE

VS A15

#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BI-E)



# ()1988 Reg. Dist. No. 2 8 2 0

#### CERTIFICATE OF DEATH

| 1. PLACE OF DEATH:  County   | 2. USUAL RESIDENCE (HOME) OF (For newborn infants giver residence of m  State Coun  City or town (if outside city or town limits.)  Street No.  (If rural, give I  2.(a) If veteran, name war.  | write RURAL and give nearest town)   |
|--|---|--|
| 3.(a) FULL NAME Pose M. Chase  |   | 3. (b) Social Security Number  |
| 4. Sex 5. Odior or race 6.(a) Single, married, widowed, or divorced  6.(b) Name of husband or wife   | 2D. DATE DF DEATH. 21 DEFENDENCE on the date for 19.1.  | e stated; Ihat Lattended deceased from   |
| 7. Birth date of deceased (mo., day, yr.)  8. AGE: Years Months Days If less than one day  7. Mary Land  9. Birthplace (Toyor, coupty, and state)  10. Usual occupation (Toyor, coupty, and state)  11. Industry or business  11. Name January Land  12. Name Mary Land  14. Maiden name Mary Land  15. Birthplace Mary Land  15. Birthplace Mary Land  16. Birthplace Mary Land  17. Birthplace Mary Land  18. Birthplace Mary Land  19. Birthplace Mary Land   | and that I last saw in alive on the Immedia of operations.  Immedia of operations.  | audits on that of death)   |
| Section   Sect | Antopsy results.  PHYSICIAN: Please underline the cause to whi  22. VIOLENCE: If death was due to external caus Accident, suicide, or homicide.  Where did Injury occur? (City or town) Injured at home, farm, Industry, public place (whi Msans of Injury  23. SIGNATURE RAUL A. C.  Address Language Comments of the cause | ch desth should he charged statistically.  es, fill in the following;  Date of |



#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-6)

# CERTIFICATE OF DEATH

Reg. Diat. No.

| 1. PLACE OF DEATH: If. Many's County  | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (For newborn infants give residence of mother)  State  County  County  |
|---|--|
| (If outside city or town limits, write RURAL and give nearest town)               | City or town Side md.  |
| How long in above place of death?   | (If outside city or town limits, write RURAL and give nearest town)  |
| 4   | Streel No.   |
| L-  | (If rural, give LOCATION)  |
| How long in hospital or institution?  | 2.(a) If veteran, name war   |
| 3. (a) FULL NAME William B. Combs   | 3. (b) Social Security Number  |
| 4. Sex   5. Color or race   8.(a) Single, married, widowed, or divorced   married | MEDICAL CERTIFICATION  20. DATE DE DEATH 1947 2131/07Pm  |
| 6.(b) Name of husband or wife Cath  | 21. I CERTIFY that death occurred on the date above stated; that I attempted deceased from   |
|   | Bhris - 19.46 10 416 8TR 19.47   |
| 7. Birth date ot  | and that I last saw h the on Coffee 25 Th 19 147   |
| deceased (mo., day, yr.) Leph. 2/18/0   | Immediate cause of death.  |
| 8. AGE: Years Mogths Days If less than one day                                    | Contract O   |
| 77hrsmin.   |  |
| ml  | - Galloner Marson Sis  |
| 9. Birthplace (Town, eounty, and state)   | Due to Supply Su |
| 1D. Usual occupation.   | and for hat the wind the state of the state  |
|   | Due to.  |
| 11. Industry or business  |  |
| 12. Name Bonfamin Sanles.  13. Birthplace M.S.                                    | Other conditions   |
| 14. Malden name. Usubusususususususususususususususususus                         | (Include pregnancy within 3 months of death)  Major findings of operations.  |
| S 15. Birtholace  |  |
| To me ( Anniha:   |  |
| 16. Informani   | Antopsy results  |
| Address Adgel, Mill.  | 22. VIOLENCE: It death was due to external causes, till in the tollowing;  |
| (Burial, cremation, or removal. Which?)  Date thereof (month) (day) (year)        | Accident, suicide, or homicide   |
| Cemetery or crematory It Michaels   | Where did Injury occur?  |
| Location Sidge MAI  | Injured at home, tarm, industry, public place (where?)   |
| 18. Funeral director P. B. Solinson   | Means of Injury Injured at work?   |
| Address Langer May .  | 1. hb . m  |
| 2/1 47 (001,001)  | 23. SIGNATURE TO GOLDEN TO THE M. D. or other  |
| 19  | Address Desmand Sayor Date signed to 10 15   |

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#### MARYLAND STATE DEPARTMENT OF HEALTH

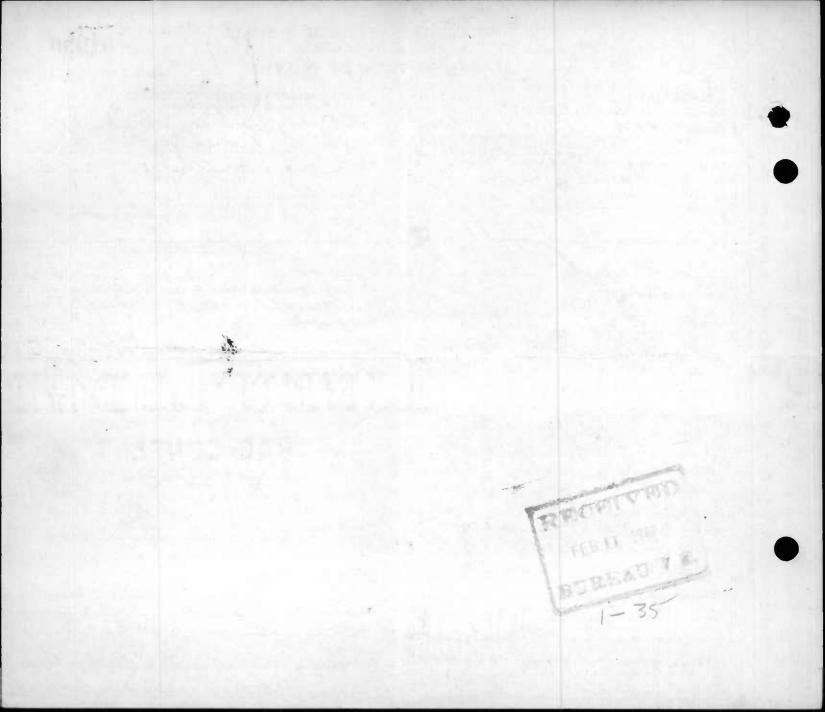
2411 N. Charles St., Baltimore 13-4)

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|   |   |   | 0 |   |   |

#### CERTIFICATE OF DEATH

Reg. Dist. No.

| 1. PLACE OF DEATH C  | 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) |
|--|---|
| County   | 20 11 000000000000000000000000000000000   |
| City or town   | State Day County County   |
| How long in above place of death?  | City or town  |
| Hospital, institution, or street address where dearn occurred:   | Street No. Leonardlawn  |
| Semandown & 150#110  | Street No   |
| How long In hospital or Institution?   | 2.(a) It veteran, name war.   |
| 3.(a) FULL NAME  |   |
| 5.(d) TOLE NAME  | 3. (b) Social Security Number   |
| nang chrobithe they  |   |
| 4. Sex 5. Color or race 6.(a) Single, married, Widowed, or proceed   | MEDICAL CERTIFICATION   |
| Themale Colord Single  | 20. DATE OF DEATH 7 21 4 90 4.  |
|  | 21. I CERTIFY that death occurred on the date above stated; that I                    |
| 6.(b) Name of husband or wife  | William & declarate any Till & T 18 4   |
| 6.(c) If alive, give age years   |   |
| 7. Birth date of deceased (mo., day, yr.) 200 2 9. 1827  | Immediais cause of death Physics Office Out       |
| 8. AGE: Years   Months   Days   If less than one day   |   |
| 19 2 // hrsmin.  | Spenderhage 1/2 hours   |
| Was the Carlo  |   |
| 9. Birthplace. (Town/county, and atate)  | Due to LALLY CHANGE   |
| 1D. Usual occupation.  |   |
| 11. Industry or business Caral M   | Due to  |
| MI 11/1 - 1 1/2 1/2  |   |
| 12. Name Cup T   | Other conditions  |
| 13. Birthplace of mary's Co  | (Include pregnancy within 8 months of death)  |
| = 14. Maiden name si cile Kplly  |   |
| 15. Sirthplace St mary's Co  | Major findings of operations.   |
| The state of the s | Date of op.   |
| 16. Informant Man Tall Control   | PHYStCIAN: Ptease underline the cause to which death should be charged statistically. |
| Address Son ardlown ma   |   |
| 17 Burial Date thereof Fish 11 1947  | 22. VIOLENCE: If death was due to external causes, fill in the following;             |
| (Burial, cremation, or removal, Which?)  Date (hereot  | Accident, suicide, or homicide  |
| Cemetery or crematory algorithms Completes   | Where did injury occur?   |
| less as allowers med   | Injured at home, farm, industry, public place (where?)                                |
| Location Office Control of the Contr | Means of Injury Injured at work?  |
| 18. Funeral director. M. C. Mallangley Sons  | 12 /2/  |
| Address Levnarslown mo   | trancia + Garagell Con  |
| Ma 47 Parealis   | 23. SIGNATURE M. D. or other  |
| 19   | Address Longaltownky Date signed Pilo & 147   |
|  |   |



VS A15

#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore /3/-0/

#### CERTIFICATE OF DEATH

| County  City or town Lawrence and County  (If outside city or town limits, write RURAL and give hearest town)  How long in above place of death?  Hospital, institution, or street address where death occupied:  How long in hospital or institution? | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (For newborn infants give residence of mother)  State  |
|--|--|
| 3. (a) FULL NAME   | 3. (b) Social Security Number<br>236-089377  |
| 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced  Office Colors  Wilderuse  | MEDICAL CERTIFICATION  20. DATE OF DEATH Teluna 3 19 47 at 2:30 Am   |
| 6.(b) Name of husband or wife  | 214 CERTIFY that death occurred on the date above stated; that lattended deceased from  18.46, to F.26.3 19.47.  and that I last saw h             |
| 8. AGE: Years Months Days If less than one dayhrsmin.  | Immediate cause of death DURATION Covebrac Hernon Rage 2 days  |
| 9. Birthplace West (Town, county, and state)  10. Usual occupation.  11. Industry or business  12. Name.  13. Birthplace   | Due to. Chronic Teplitis 15 years  Dither conditions   |
| 14. Maiden name 2 Minron  15. Birthplace   | (Include pregnancy within 3 months of death)  Major findings of operations   |
| 16. Informant All Shares Marfaul  17. Burnel  18. Informant Marfaul  19.47  (Burnel, cremation, or removal. Which?)  Cemetery or crematory. Limit House Burnel  19.47  | Autopsy results  |
| Location Man Cernardon M. C. Mathempley Sons  18. Funeral director W. C. Mathempley Sons  Address Language M. C. Mathempley Sons  19. 19. 19. 7. Assessed  | injured al home, farm, industry, public place (where?)  Means of injury  The latest M.D. or other  P. L. D. T. Jan J. M.D. or other  23. SIGNATURE |



correct age

# VS A15

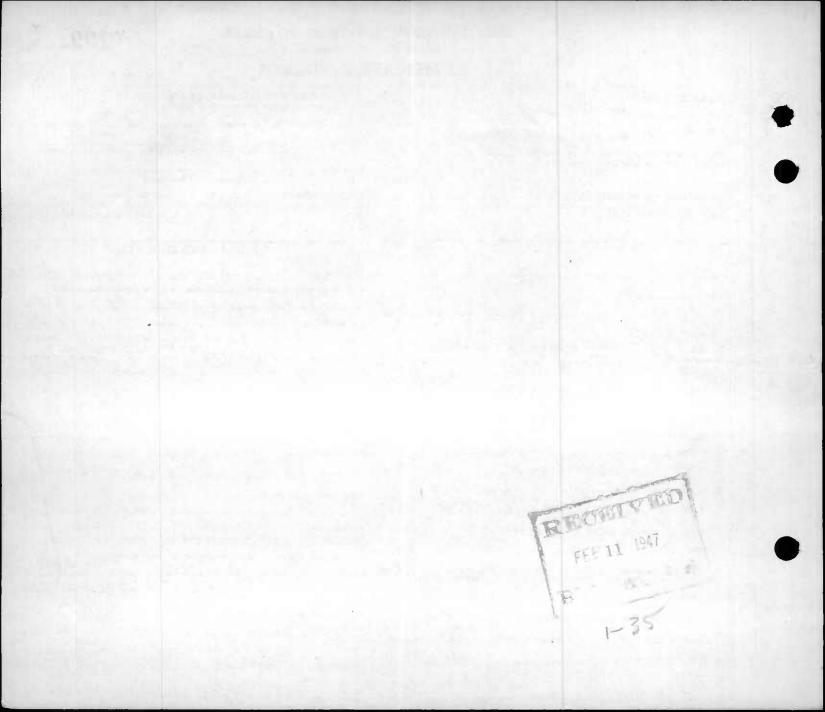
#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

#### CERTIFICATE OF DEATH

#1992

| County   | 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infents give residence of mother)  State   |
|--|--|
| S.(a) POLE NAME  | 3. (b) Social Security Number  |
| Charles Melba Xucar  |  |
| 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced            | MEDICAL CERTIFICATION  |
| male white Single  | 20. DATE OF DEATH. 7. 19.4.7. 21 2.30. P. W  |
| 6.(b) Name of husband or wife  | 21. I CERTIFY that death occurred on the data above stated: that I attended deseased from  |
|  | William & Cleaned OH The 8/ 1947.  |
| 7. Birth date of   | and that I last saw h  |
| deceased (mo., day, yr.)  8. AGE: Years   Months   Days   If less than one day | Immediais cause of death Level Cal May Mills DURATION  |
| 6. AGE.  | for the state of t |
| 3 0  hrsmin.   | allysical long full all molisy   |
| 9. Birthplace Draft (Town, Jounty, and stage)                                  | Due to Dhart Glass About 18 M. A.  |
| 10. Usual occupation   | Due to   |
| 11. Industry or business   |  |
| 12. Name Charles Fucas  13. Birthplace Baltumore md                            | Dther conditions   |
|  | (Include pregnancy within 3 months of death)   |
| 14. Maiden name Helen, Martin  |  |
| 14. Maiden name Helen, martin<br>St. Birthplace It marys co                    | Major fiedings of operations   |
| 16. Informant Pelham Aveas   | Aotopsy results  |
| - 10   | PHYSICIAN: Please underline the caose to which death shoold be charged statistically.  |
| Address Compton M 4  17. Ducked Date thereof. The Compton (month) (doy) (year) | 22. VIOLENCE: If death was due to external causes, fill in the following:  Accident, suicide, or homicide  |
|  | A II by the his in A A   |
| Cemetery or crematory of Carel Cemetery ME.                                    | Where did injury occur? 23.1. A. A. A. A. C. (City or town) (County), (State)  |
| Location Llygardtown mid   | Injured at home, farm, Industry, public place (where?)   |
| 18. Funeral director W. C. Mathingley Sous                                     | Means of Injury Shall Game Injured at work?  |
| Address Seonardown md  | 23. SIGNATURE FRANCIS & FREEZISCH Coroner  |
| 19. 2/9 (Date rec'd by registrar)  (Date rec'd by registrar)                   | Address Addres |



ect age

PLAINLY, WITH UNFADING INK. Supply every item of information carefully is especially important. Physicians: please write the causes of death clearly and

WRITE

PLEASE

FOR BINDING

MARGIN RESERVED

2411 N. Charles St., Baltimore 942

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#### CERTIFICATE OF DEATH

9810

| CERTIFICAT   | Reg. Dist. No. 2.   |
|--|---|
| 1. PLACE OF DEATH:  County   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (Egr newborn infants give residence of mother)  State   |
| 3.(a) FULL NAME  |   |
| John Henry Ower  | 3. (b) Social Security Number   |
| Male White (a) Single, married, widowed, or divorced   | MEDICAL CERTIFICATION  20. DATE OF DEATH Lehenary 13 1947, al6:50 P.  |
| 6.(b) Name of husband or wife  | 21. I CERTIFY that death occurred on the date above stated: that I artended deceased from  19.45 to F4.3 19.47.  and that I last saw because alive on F4.7. |
| 7. Birth date of deceased (mo., day, yr.)  8. AGE: Years   Monihs   Days   If less than one day  | Immediate cause of death OURATION   |
| 3-3 3 10 hrs   | P   |
| 9. Birthplace (Toyn, eounty, and state)  10. Usual occupation (Tuxunum)  | Oue to.  Oue to.  Oue to.  Oue to.  |
| 11. Industry or business  12. Name  13. Birthplace   | Other conditions.   |
| 14. Maiden name Carache F. Burnaughs  15. Birthplace Maryland.   | (Include pregnancy within 3 months of death)  Major fiedings of operations  |
| 16. Informant Cada Bigles  | Actors results  |
| Address Stead Date thereof (Burial, cremation, or removed, Whigh?)  (Burial, cremation, or removed, Whigh?)  (Burial, cremation, or removed, Whigh?) | 22. VIOLENCE: If death was due to external causes, fill in the following;  Accident, suicide, or homicide   |
| Gemetery or crematery Millel Millel Mil  | (City or town) (County) (State)   |
| Location Alas Annuagon   | Means of Injury Injured at work?  |
| Address A anash Januar   |   |
| 19. Test 13 1947 Py Ban Registrar  | Address Great Mills M. D. or other M. D. or other M. D. Date signed 1/4/4.7   |

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and so to wind some he goes

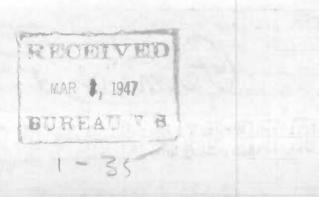
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# PLEASE WRITE PLAINLY, WITH UNFADING LAK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly BESERVED FOR BINDING MARGIN

VS-A15

| /   |  |  | CERTIFICA  | TE OF DEATH  | Reg. Dist. No.  | 820         |
|---|--|--|--|--|---|-------------|
| City or town                              | e of death?  street address where  y U.S. N  or institution? | ver<br>imits, write RUR<br>months<br>death occurred:<br>aval Air | AL and give nearest town)  Station.                  | 2. USUAL RESIDENCE (HOME) (For newborn infants give residence of the control of t | County  Alts, write RURAL and give ne   | arest town) |
|   | MORTON "   | J" ROTMA   | N  |  | *   |             |
| 4. Sox                                    | 5. Color or race   | 6.(a) Single, m  | arried, widowed, or divorced                         | MEDICAL (  | CERTIFICATION   |             |
| Male                                      | White  | Sin  | gle  | 20. DATE OF DEATH 26 Februa  | rv 19 47  | 5:30 I      |
| 6.(b) Name of husband<br>7. Birth dato of | d or wife  |  | alive, give ageyears                                 | 21. I CERTIFY that death occurred on the date a 26 February 1 and that I last saw him alive on 26  | above stated; that I aftended dece<br>947 to 26 Febru                                 | asod from   |
| docoased (mo., day,                       |  |  |  | Immediate cause of death Shock at  |   | DURATION    |
| 8. AGE: Year                              |  | Days   | If less than one dayhrsmin.                          |  |   |             |
|   | New Roch (Town, Ensign ss U. S. Morris                       | elle. Ne county, and stat  |  | Due to   | 3 months of death) supurative appe  |             |
| Address  11                               | Official I<br>US NAS, P.                                     | Navy Recaturent  Date thereof.  Funeral  wn, Mary                | 2-28-147<br>(month) (day) (year)<br>7alaaaal<br>Home | Autopsy results. Acute Supural PHYSICIAN: Please underline the cause to  22. VIOLENCE: If death was due to external of Accident, suicide, or homicide  | tive appendicit which death should be charged causes, fill in the following;  Date of | (State)     |

| (If run<br>2.(a) If veferan, name war Worl   | ral, give LOCATIO<br>d War II             | (MC                              |                             |
|--|---|----------------------------------|-----------------------------|
|  |   | Social Securi                    | ity Number                  |
| MEDIC  | AL CERTIF                                 | ICATION                          |                             |
| 20. DATE OF BEATH 26 Feb.  | ruary                                     | 19. 4                            | 7 5:30 P                    |
| 21. I CERTIFY that death occurred on the 26 February and that I last saw h 1 malive on | date above stated;<br>19.47 t<br>26 Febru | that I affended d<br>26 February | eceased from<br>ruary 19 47 |
| Immediate cause of deathShocl  | c and Tox                                 | cemia                            | DURATION                    |
| Due to Appendicitis<br>Ether enesthe   | esia                                      |                                  |                             |
| Other conditions   |   |                                  |                             |
| (Include pregnancy v   | te supura                                 | tive ap                          | 2-26-47                     |
| PHYSICIAN: Please underline the car  | se to which death                         | should be char                   | red statistically.          |
| 22. VIOLENCE: If death was due to ex   |   |                                  |                             |
| Accident, suicide, or homicide   |   |                                  |                             |
| Where did injury occur?(City of  | r town)                                   | (County)                         | (State)                     |
| Injured at home, farm, Industry, public  |   |                                  | ************************    |
| Means of Injury  KNOX PIT  | Bud                                       | R, MC US                         | N<br>D, or other            |



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#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimor

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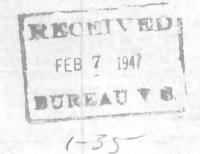
#### CERTIFICATE OF DEATH

(11995 Reg. Diat. No. 2820

| 1. PLACE OF DEATH: 11. 7   | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (For newborn infants give residence of mother)   |
|--|--|
| County   | March land of many   |
| (If outside city or town limits, write RURAL and give nearest town)      | market County and the Tab.   |
| Now long in above place of death?  | (If outside city or town limits, write RURAL and give nearest town)  |
| Hospital, Institution, or street address where, death occurred:          | Street Ho.   |
|  | (If rural, give LOCATION)  |
| How long in hospital or Institution?                                     | 2.(a) It veteran, name war.  |
| 3. (a) FULL NAME James Bichard Ta  | 3. (b) Social Security Number  |
| 4. Sex 5. Color or race 8.(a)Single, married, widowed, or divorced       | MEDICAL CERTIFICATION  |
| male coloud musical-   | OR DATE DE DEATH FLOT LA LAND IN   |
| may C. Taylor  | 20. DATE DF DEATH  |
| 6.(0) Namo of nusuano of wife  | and the state of the state above states; that a state decrees the state of the stat |
| 7. Birth date of   | and that I last saw J. V. alive on Felc. 3 1 447 19  |
| deceased (mo., day, yr.) Syplember 23 1899                               | Immediate cause of death DURATION  |
| 8. AGE: Years Months Days If less than one day                           | Suldural Hemorry 541-47  |
| 48hrsmin.  |  |
| 9. Birthplace Maryland   | Due to to vassine My ferline 3 to  |
| (Toya, county, and state)  | 100  |
| 10. Usual occupation   | Due to September Supports  |
| 11. Industry or business   |  |
| 12. Name Jasses 4 - Jaylan   | Other conditions   |
|  | (Include pregnancy within 3 months of death)   |
| 14. Maiden vame Mallie Baenes  | Major findings of operations AMM diml  |
| 15. Birthplace Maryland  | Date of on.  |
| 16. totorman Mary C & Yaular   | Autopsy results.   |
| Address mo Pravia wille med  | PHYSICIAN: Please underline the cause to which death should be charged statistically.  |
| D. 110 12/117  | 22. VIOLENCE: It death was due to external causes, till in the tollowing;  |
| (Burial, cremation, or remove, Which?) Date thereot (month) (day) (year) | Accident, suicide, or homicide   |
| Cemetery or crematory for house  | Where did injury occur?  |
| Location Hallyhund   | Injured at home, farm, Industry, public place (where?)   |
| RAB PR V.  | Means of Injury Injured at work?   |
| 18. Funeral director   | 04   |
| Address flonasalous Ma.  | 23. SIGNATURE PLANETUS Q. Weld M.D.  |
| 19. 7/8 Camaley  | M. D. or other 47  |
| 19   | Address Dato signed 2477   |

WITH TO THE SECTION OF T

Mary and Sales



#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



| CERTIFICATE OF DEATH  Reg. Diat. No  |   |
|--|---|
| County City or town. City or town limits, write RURAL and give nearest town)  How long in ebove place of death? Hospital, institution, or stroot address where death occurred: | 2. USUAL RESIDENCE (HOME) OF DECEASED:  (For newboro infants give residence of mother)  State |
| 3. (a) FULL NAME  1  | 3. (b) Social Security Number   |
| 5. Color of race b.(a) Single, married, widowed, or divorced   | MEDICAL CERTIFICATION  20. DATE OF DEATH. 2 19.4 7 at 6 7 M                                   |
| 5.(b) Name of husband or wife  | 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  2  |
| 9. Birthplace  | Due to Sphanes  |
| 11. Industry or business 12 20 20 20 20 20 20 20 20 20 20 20 20 20   | Differ conditions Jackson a within 3 months of death)   |
| 14. Maiden name Drive Forcis Streetly 15. Birthplace Vally The Ung   | Major findings of operations  |
| Addross alexander 2 - 5 - 40   | Autopsy results   |
| (Burial, cremation, or removal. Which?)  Date thereof (month) (day) (year)  Cemetery or crematory.   | Accident, suicide, or homicide  |
| Location Statement 18. Funoral director La Than Theory   | Injured at home, farm, Industry, public place (where?)  Means of Injury  Injured at work?     |
| 19. 2 - 4 - 19. 4 ) M. V. Valence (Date ree'd by registrar)  Registrar   | 23. SIGNATURE TWOM'V value  M. D. or other  Address Green Bate signed 2                       |

VS A15

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- Warrens meretines a la placement State of the allege and the second TREE . FEB 11 1947 BUTTE 1.35 Washington Mill Charles and Francisco Control Control Control

VS A15

#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-20

### CERTIFICATE OF DEATH

| 1. PLACE OF DEATH: 54  | 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)     |
|--|---|
| County   | State Maryland county St. mary.   |
| City or town   | 1 Now Of the med  |
| How long in above place of death?  | City or town  |
| Hospital, institution, or street address where death occurred:   | Street No.  |
| St. mans Hopital   | (If rural, give LOCATION)   |
| Row long In hospital or institution? 4 days -  | 2.(a) If veteran, name war  |
| 3. (a) FULL NAME   | 3. (b) Social Security Number   |
| 22 2. 4  |   |
| 4. Sex   5. Color optace / 6.(a) Single, maggled, widowed, or divorced   | MEDICAL CERTIFICATION   |
| 4.551  |   |
| Temele Calored Widowed   | 20. DATE OF DEATH. Feb. 10 = 19.4.7 21 7 19.10  |
|  | 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from |
| 6.(b) Name of husband or wife  | Feb, 6 1947 10 7et 10 1841.   |
| 7. Birth date of   | and that I last saw h alive on 7el. 9   |
| deceased (mo., day, yr.) nat known 1877  | Immediate cause of death  |
| 8. AGE: Years   Months   Days   If less than one day   | Gangren left Foot 4 Weeks   |
| 70 ?   |   |
|  | Endarthilis Obliterano ?  |
| 8. Birthplace  | Due to.   |
| the same of the sa | Bear Generalized arteris schools ?  |
| 10. Usual occupation.  | Due 1c.   |
| 11. Industry or business Conc  | Oh is Surger di Li  |
| # 12. Name Met Known   | Other conditions Chronic mycarditis.  |
| 13. Birthplace   | (Iuclude pregnaucy within 3 months of death)  |
| 14 Malden name net Known   |   |
| 14. Malden name Net Known  15. Birthplace  ?   | Major findings of operations. Aland down  |
|  | none done   |
| 16. Informant Charles Browner:   |   |
| Address Chaptico maylond.  | PHYSICIAN: Please underline the cause to which death should be charged statistically.     |
| 0 1 1 12 447   | 22. VIOLENCE: If death was due to external causes, fill in the following:                 |
| (Burial, cremation, or removal. Which?)  Date thereof. (month) (day) (year)  | Accident, suicide, or homicide  |
| I have a later than it is the same in the  | Where did injury occur?   |
| Cemetery or crematory.   | Injured at home, farm, Industry, public place (where?)                                    |
| Location Mosganza  |   |
| 18. Funaral director Rose & Welch.   | Means of Injury Injured all work?   |
| Olitica med.   | 01 · N/1/2/22   |
| Address hopico   | 23. SIGNATURE M. D. or other  |
| 19 M/1 1947 Camalies   | Chaptice St Mary Co Medio signed 2/11/47  |
| (Dato rec'd hy registrar) Registrar  | Address Manual Mary Marie signed  |

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